Employer Compliance Alert

Garner Insurance Services

AGENCIES ISSUE REGULATIONS UNDER MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

Over a year after the Mental Health Parity and Addiction Equity Act (MHPAEA) was enacted (and after the statutory provisions took effect for most group health plans); the Departments of Labor, Health and Human Services, and Treasury have finally issued interim final regulations implementing the provisions of the MHPAEA. The regulations are welcome guidance for many plan sponsors who have thus far been forced to interpret the statutory requirements on their own.

As explained in our November 2008 article, the MHPAEA expanded the Mental Health Parity Act of 1996 ("MHPA") provisions for group health plans. The original MHPA required parity in aggregate lifetime and annual dollar limits for mental health benefits and medical/surgical benefits. However, it did not apply to substance use disorder benefits. Nor did it bar other types of limitations on mental health benefits (such as annual limits on the number of outpatient treatments).

The MHPAEA not only broadened the MHPA parity rules as they apply to mental health benefits, but also extended those rules to substance use disorder benefits. The new requirements became effective for plan years beginning after October 3, 2009.

Application of MHPAEA

The MHPAEA applies to (i) group health plans sponsored by private and public sector employers with more than 50 employees, including self-insured as well as fully insured arrangements; and (ii) health insurance issuers who sell coverage to employers with more than 50 employees. The regulations generally take effect for plan years beginning on or after July 1, 2010 (January 1, 2011, for calendar-year plans). Collectively bargained plans are subject to a special delayed effective date. In the meantime, plan sponsors must still make a good faith attempt to comply with the statutory requirements.

New Definitions

The regulations amend the definitions of "medical/surgical benefits" and "mental health benefits," and add a definition of "substance use disorder benefits." Medical/surgical benefits are benefits for medical or surgical services, as defined under the terms of the plan or health insurance coverage, but do not include mental health or substance use disorder benefits. Mental health benefits and substance use disorder benefits are benefits with respect to services for mental health conditions and substance use disorders, as defined under the terms of the plan and in accordance with applicable federal and state law.

The regulations also provide that plan terms defining whether the benefits are mental health or substance use disorder benefits must be consistent with generally recognized independent standards of current medical practice. This requirement is intended to prevent plans from intentionally mischaracterizing a benefit in order to avoid complying with the MHPAEA requirements.

Financial Requirements and Treatment Limitations

The MHPAEA requires that mental health and substance abuse benefits be no more restrictive than the *predominant* financial requirement or treatment limitation applied to *substantially* all medical/surgical benefits (the italicized terms are defined below). The regulations clarify that this analysis must be applied separately for each of the following six categories:

- inpatient in-network
- inpatient out-of-network
- outpatient in-network
- outpatient out-of-network
- emergency care
- prescription drugs.

The regulations also state that medical management standards and other *nonquantitative* treatment limitations (*e.g.,* formulary design, step therapy, etc.) must apply to mental health or substance use disorder benefits in a way that is comparable to and no more stringent than the way they apply to medical/surgical benefits - unless recognized clinically appropriate standards of care would permit such a difference. For example, plans cannot require participants to exhaust employee assistance plan counseling benefits before being eligible for mental health or substance use disorder benefits if there is no comparable exhaustion requirement for medical/surgical benefits.

Under the regulations, the *predominant* financial requirement or treatment limitation is one that applies to more than one-half of medical/surgical benefits that are subject to financial requirements or quantitative treatment limitations in that classification. A financial requirement or treatment limitation applies to *substantially all* medical/surgical benefits in a classification if it applies to at least two-thirds of all medical/surgical benefits in the classification, based on the dollar amount of benefits expected to be paid for the plan year. Any reasonable method may be used to determine the dollar amount expected to be paid under the plan.

Specifically, a plan may not apply cumulative financial requirements or cumulative quantitative treatment limitations to mental health or substance use disorder benefits that accumulate separately from cumulative financial requirements or quantitative treatment limitations established for medical/surgical benefits. So, for example, a plan must not only provide the *same* deductible; it must be a *combined* deductible.

Even before the regulations were issued, most plan sponsors understood that the MHPAEA did not *require* plans to provide any mental health or substance use disorder benefits. Thus, some plan sponsors were considering whether to eliminate mental health and/or substance use disorder benefits rather than comply with the MHPAEA. However, it was not clear whether a plan sponsor could choose to provide one type of benefit (*e.g.*, mental health benefits), yet exclude another (e.g., substance use disorder benefits). The regulations now clarify that providing benefits for one or more mental health conditions or substance use disorders does not require benefits to be provided for any other condition or disorder.

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Cost Exemption

One question that remains unanswered by the regulations is how to interpret the MHPAEA cost exemption. Under the statute, group health plans that can demonstrate a cost increase of at least one percent (two percent for the first year this new rule applies to the plan) may apply for an exemption from the law's requirements. If granted, the exemption applies prospectively, for one year at a time. According to the regulations, guidance on the cost exemption will be issued "in the near future."

One thing seems clear, however. The best a plan can hope for is to obtain the exemption every other year. This is because the plan will need data from alternate years to qualify for the exemption during each of the following years.

Disclosure Requirements

The MHPAEA includes two new disclosure provisions for group health plans. First, the criteria for medical necessity determinations with respect to mental health or substance use disorder benefits must be made available to any current or potential participant, beneficiary, or contracting provider upon request. Second, the reason for any claim denial must be made available, upon request, to the participant or beneficiary. The regulations clarify that, in order for plans subject to ERISA to satisfy this requirement, disclosures must comply with the ERISA claims and appeals procedure regulations. This means that such disclosures must be provided automatically and free of charge.

Next Steps

In light of the regulations, plan sponsors should promptly review their plan documents and plan design to ensure that their plans comply with all aspects of the new rules.

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